New York State Board for Professional Medical Conduct
433 River Street, Suite 303 • Troy, New York 12180-2299 • (518) 402-0863

Antonia C. Novello, M.D.,M.P.H., Dr. P.H.
Commissioner
NYS Department of Health

Dennis P. Whalen
Executive Deputy Commissioner
NYS Department of Health

Dennis J. Graziano, Director
Office of Professional Medical Conduct

William P. Dillon, M.D.
Chair

Denise M. Bolan, R.P.A.
Vice Chair

Ansel R. Marks, M.D., J.D.
Executive Secretary

December 12, 2001

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Arvinder Jit Sachdev, M.D.
2200 Main Street
Buffalo, New york 14214

RE: License No. 119612

Dear Dr. Sachdev:

Enclosed please find Order #BPMC 01-298 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect December 12, 2001.

If the penalty imposed by the Order is a surrender, revocation or suspension of this license, you are required to deliver to the Board the license and registration within five (5) days of receipt of the Order to Board for Professional Medical Conduct, New York State Department of Health, Hedley Park Place, Suite 303, 433 River Street, Troy, New York 12180.

Sincerely,

Ansel R. Marks, M.D., J.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure
cc: Brian P. Fitzgerald, Esq.
Napier, Fitzgerald and Kirby
509 Liberty Building
420 Main Street
Buffalo, NY 14202

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

ARVINDER JIT SACHDEV, M.D.

CONSENT
AGREEMENT
AND
ORDER

BPMC No. 01-298

ARVINDER JIT SACHDEV, M.D., (Respondent) says:

That on or about March 22, 1974, I was licensed to practice as a physician in the State of New York, having been issued License No. 119612, by the New York State Education Department.

My current address is 2200 Main Street, Buffalo, New York 14214, and I will advise the Director of the Office of Professional Medical Conduct of any change of my address.

I understand that the New York State Board for Professional Medical Conduct has charged me with eight specifications of professional misconduct.

A copy of the Statement of Charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

I plead no contest to the Fifth Specification as it pertains to factual allegations C.2, C.3 and D.4, and the Eighth Specification as it pertains to factual allegation F.4. In full satisfaction of the charges against me, I hereby agree to the following penalty:

1. A two year suspension of my medical license, stayed on the condition of my compliance with the monitoring terms set forth in Exhibit B, hereto.

2. The successful completion of a clinical competency assessment and a personalized continuing medical education program in accordance with the terms set forth in Exhibit B, hereto.

3. Prospective monitoring of 200 gastroenterology procedures in accordance with terms set forth in Exhibit C, hereto.

I further agree that the Consent Order for which I hereby apply shall impose the following conditions:

That, except during periods of actual suspension, Respondent shall maintain active registration of Respondent's license with the New York State Education Department Division of Professional Licensing Services, and pay all registration fees. This condition shall be in effect beginning thirty days after the effective date of the Consent Order and will continue while the licensee possesses his/her license; and

That Respondent shall fully cooperate in every respect with the Office of Professional Medical Conduct (OPMC) in its administration and enforcement of this Order and in its investigation of all matters regarding Respondent. Respondent shall respond in a timely manner to each and every request by OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall meet with a person designated by the Director of OPMC as directed. Respondent shall respond promptly and provide any and all documents and information within Respondent's control upon the direction of OPMC. This condition shall be in effect beginning upon the effective date of the Consent Order and will continue while the licensee possesses his/her license.

I hereby stipulate that any failure by me to comply with such conditions shall constitute misconduct as defined by New York State Education Law §6530(29).

I agree that in the event I am charged with professional misconduct in the future, this agreement and order shall be admitted into evidence in that proceeding.

I hereby make this Application to the State Board for Professional Medical Conduct (the Board) and request that it be granted.

I understand that, in the event that this Application is not granted by the Board, nothing contained herein shall be binding upon me or construed to be an admission of any act of misconduct alleged or charged against me, such Application shall not be used against me in any way and shall be kept in strict confidence during the pendency of the professional misconduct disciplinary proceeding; and such denial by the Board shall be made without prejudice to the continuance of any disciplinary proceeding and the final determination by the Board pursuant to the provisions of the Public Health Law.

I agree that, in the event the Board grants my Application, as set forth herein, an order of the Chairperson of the Board shall be issued in accordance with same. I agree that such order shall be effective upon issuance by the Board, which may be accomplished by mailing, by first class mail, a copy of the Consent Order to me at the address set forth in this agreement, or to my attorney, or upon transmission via facsimile to me or my attorney, whichever is earliest.

I am making this Application of my own free will and accord and not under duress, compulsion or restraint of any kind or manner. In consideration of the value to me of the acceptance by the Board of this Application, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive any right I may have to contest the Consent Order for which I hereby apply, whether administratively or judicially, and ask that the Application be granted.

DATED 11/28/2001

ARVINDER JIT SACHDEV, M.D.
RESPONDENT

The undersigned agree to the attached application of the Respondent and to the proposed penalty based on the terms and conditions thereof.

DATE: 11/28/01

BRIAN P. FITZGERALD, ESQ.
of Counsel, Napier, Fitzgerald & Kirby
Attorneys for Respondent

DATE: 12/3/01

TIMOTHY J. MAHAR, ESQ.
Associate Counsel
Bureau of Professional
Medical Conduct

DATE: 12/7/01

DENNIS J. GRAZIANO
Director
Office of Professional
Medical Conduct

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

ARVINDER JIT SACHDEV, M.D.

CONSENT

ORDER

Upon the proposed agreement of ARVINDER JIT SACHDEV, M.D. (Respondent) for Consent Order, which application is made a part hereof, it is agreed to and

ORDERED, that the application and the provisions thereof are hereby adopted and so ORDERED, and it is further

ORDERED, that this order shall be effective upon issuance by the Board, which may be accomplished by mailing, by first class mail, a copy of the Consent Order to Respondent at the address set forth in this agreement or to Respondent's attorney by certified mail, or upon transmission via facsimile to Respondent or Respondent's attorney, whichever is earliest.

SO ORDERED.

DATED: 12/10/01

William P. Dillon, M.D.
WILLIAM P. DILLON, M.D.
Chair
State Board for Professional
Medical Conduct

Exhibit A

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
ARVINDER JIT SACHDEV, M.D.	:	CHARGES

----------X

Arvinder Jit Sachdev, M.D., the Respondent, was authorized to practice medicine in New York State on March 22, 1974 by the issuance of license number 119612 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine.

FACTUAL ALLEGATIONS

A. Respondent performed colonoscopy procedures on Patient A on December 3, 1991, March 5, 1992, April 19, 1993, May 25, 1994, October 4, 1994, and on October 31, 1995, at Sisters Hospital in Buffalo, New York (Patients are identified in Appendix A hereto). Respondent performed a barium enema study on Patient A on October 31, 1995, at Sisters Hospital for a tortuous colon. Respondent's care and treatment of Patient A failed to meet acceptable standards of medical care in that:

1. Respondent, during the December 3, 1991 colonoscopy, failed to adequately describe a polyp in Patient A's colon which Respondent described post-procedure as suspicious for cancer.
2. Respondent, during the December 3, 1991 colonoscopy,

failed to take an adequate number of biopsies of the polyp which Respondent described post-procedure as suspicious for cancer.

3. Respondent performed the March 5, 1992 colonoscopy which was unnecessary or without adequate medical indication. In the alternative, the colonoscopy performed by Respondent on April 19, 1993 was unnecessary or without medical indication in view of the colonoscopy performed on March 5, 1992, and the results obtained from that procedure.

4. Respondent failed to adequately describe, remove and/or biopsy a rectal polyp seen during the March 5, 1992 colonoscopy.

5. Respondent performed the May 25, 1994 colonoscopy, which was unnecessary or without adequate medical indication.

6. Respondent failed to adequately describe, remove and/or biopsy a small cecal polyp as seen during the May 25, 1994 colonoscopy.

7. Respondent performed the October 4, 1994 colonoscopy which was unnecessary or without adequate medical indication.

8. Respondent performed the October 31, 1995 colonoscopy which was unnecessary or without adequate medical indication.

9. Respondent performed a barium enema study on October 31, 1995, the same day in which he performed a sigmoidoscopy, contrary to accepted standards of

medical care.

10. Respondent failed to maintain an adequate medical record for Patient A.

B. Respondent performed a colonoscopy procedure on Patient B on February 21, 1995 at St. Joseph's Hospital in Buffalo, New York. Respondent's care and treatment of Patient B failed to meet acceptable standards of medical care in that:

1. Respondent ordered one or more volume lavages for Patient B, for bowel preparation preceding colonoscopy, which bowel preparation was contraindicated. Among the reasons this preparation was contraindicated were CT findings on February 20, 1995 suspicions for bowel perforation.
2. Respondent performed a colonoscopy on Patient B on February 21, 1995, which was contraindicated. Among the reasons the colonoscopy was contraindicated were CT findings on February 20, 1995 suspicions for bowel perforation
3. Respondent failed to obtain a surgical consultation prior to performing a colonoscopy on February 21, 1995, in circumstances in which a CT of Patient B's abdomen suggested bowel perforation.

C. Respondent provided medical care to Patient C at his offices, then located at 2200 Main Street, Buffalo, New York 14214 (hereinafter Respondent's office) and at Sisters Hospital in Buffalo, New York during the period including October 13, 1994

through November 1, 1994 and during which time Respondent performed two endoscopic retrograde cholangiopancreatography procedures (ERCP) for, among other things, obstructive jaundice. Respondent's care and treatment of Patient C failed to meet acceptable standards of medical care in that:

1. Respondent failed to adequately evaluate Patient C, including the failure to take an adequate history and/or perform an adequate physical examination, prior to the ERCP procedures performed on October 13, 1994 and/or on November 1, 1994.
2. Respondent failed to order Patient C to take prophylactic antibiotics prior to the October 13, 1994 ERCP procedure.
3. Respondent failed to order Patient C to take prophylactic antibiotics prior to the November 1, 1994 ERCP procedure.
4. Respondent failed to establish adequate drainage of the common bile duct during the October 13, 1994 ERCP procedure, and/or failed to refer Patient C for appropriate treatment at that time.
5. Respondent failed to adequately treat Patient C for obstructive jaundice during the period between October 13, 1994 and November 1, 1994.
6. Respondent failed to maintain an adequate medical record for Patient C.

D. Respondent performed an ERCP study on June 6, 1994, on Patient D for an elevated alkaline phosphatase and then a second ERCP study on June 9, 1994, for a dilated common bile duct at Sisters Hospital in Buffalo, New York. Respondent's care and treatment of Patient D failed to meet acceptable standards of medical care in that:

1. Respondent failed to adequately evaluate Patient D's elevated alkaline phosphatase prior to the June 6, 1994 ERCP procedure.
2. Respondent failed to adequately evaluate and/or treat Patient D for what Respondent described as a "very extensively dilated [common bile] duct" during the June 6, 1994 ERCP procedure.
3. Respondent failed to properly perform a sphincterotomy or by other means establish adequate drainage from the common bile duct during the June 9, 1994 ERCP procedure.
4. Respondent failed to adequately assess symptoms of cholangitis following the June 9, 1994 ERCP procedure.
5. Respondent failed to maintain an adequate medical record for Patient D.

E. Respondent performed colonoscopy procedures on Patient E on December 8, 1995, and on August 16, 1996 for a colonic stricture at St. Joseph's Hospital in Buffalo, New York. Respondent's care and treatment of Patient E failed to meet acceptable standards of medical care in that:

1. Respondent failed to adequately evaluate Patient E prior to the August 16, 1996 colonoscopy, including the failure take an adequate history and/or perform an adequate physical examination.
2. Respondent failed to adequately assess and/or manage Patient E's elevated blood pressure of 250/130, and/or indications of patient discomfort during the August 16, 1996 colonoscopy.
3. Respondent during the colonoscopy performed on August 16, 1996, failed to evaluate and/or report on a polyp initially observed during the colonoscopy performed on December 8, 1995.
4. Respondent failed to maintain an adequate medical record for Patient E.

F. Respondent performed an esophagogastroduodenoscopy (EGD) procedure on Patient F on April 11, 1995 at the Sisters Hospital in Buffalo, New York. Respondent's care and treatment of Patient F failed to meet acceptable standards of medical care in that:

1. Respondent failed to appropriately identify Patient F prior to performing an EGD procedure which had been planned for another patient, and not for Patient F. Patient F did not require an EGD procedure.
2. Respondent performed an EGD procedure on Patient F which had been planned for another patient.
3. Respondent failed to maintain an adequate medical record for Patient F, including, but not limited to, the failure to document that portion of an EGD

procedure which had been performed on Patient F.

SPECIFICATIONS

FIRST AND SECOND SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(4) by reason of his practicing the profession of medicine with gross negligence on a particular occasion, in that Petitioner charges the following:

1. The facts set forth in paragraphs B and B.1 and/or B and B.2 and/or B and B.3.
2. The facts set forth in paragraphs F and F.1 and/or F and F.2 and/or F and F.3.

THIRD AND FOURTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(6) by reason of his practicing the profession of medicine with gross incompetence on a particular occasion, in that Petitioner charges the following:

3. The facts set forth in paragraphs B and B.1 and/or B and B.2 and/or B and B.3.
4. The facts set forth in paragraphs F and F.1 and/or F and F.2 and/or F and F.3.

FIFTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(3) by reason of his practicing the profession of medicine with negligence on more than one occasion, in that Petitioner charges two or more of the following:

5. The facts set forth in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8, A and A.9, B and B.1, B and B.2, B and B.3, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, D and D.1, D and D.2, D and D.3, D and D.4, E and E.1, E and E.2, E and E.3, F and F.1, and/or F and F.2.

SIXTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(5) by reason of his practicing the profession of medicine with incompetence on more than one occasion, in that Petitioner charges two or more of the following:

6. The facts set forth in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, A and A.7, A and A.8, A and A.9, B and B.1, B and B.2, B and B.3, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, D and D.1, D and D.2, D and D.3, D and D.4, E and E.1, E and E.2, E and E.3, F and F.1, and/or F and F.2.

SEVENTH SPECIFICATION

ORDERING EXCESSIVE TESTS

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(35) by reason of his having ordered excessive tests of a patient not warranted by the condition of the patient, in that Petitioner charges the following:

7. The facts set forth in paragraphs A and A.3, and/or A and A.5, and/or A and A.7, and/or A and A.8.

EIGHTH SPECIFICATION

INADEQUATE RECORDS

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(32) by reason of his failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in that Petitioner charges the following:

8. The facts set forth in paragraphs A and A.10, and/or C and C.6, and/or D and D.5, and/or E and E.4, and/or F and F.3.

DATED: March 29, 2001
Albany, New York

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct

EXHIBIT B

CONSENT ORDER

SUSPENSION, STAYED WITH TERMS OF MONITORING, CLINICAL COMPETENCY AND PERSONALIZED CONTINUING MEDICAL EDUCATION

1. Respondent shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his profession.

2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street, Suite 303, Troy, NY 12180-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.

3. Respondent shall fully cooperate with and respond in timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.

4. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by New York State. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses (Tax Law §171(27); State Finance Law §18; CPLR §5001; Executive Law §32).

5. The period of suspension, stayed with conditions shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall notify the Director again prior to any change in that status. The period of suspension, stayed with conditions shall resume and any terms of monitoring which were not fulfilled shall be fulfilled upon Respondent's return to practice in New York State.

6. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and his staff at practice locations or OPMC offices.

7. Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

8. Respondent shall obtain a clinical competency assessment performed by a program for such assessment as directed by the Director of OPMC. Respondent shall cause a written report of such assessment to be provided directly to the Director of OPMC within sixty (60) days of the effective date of this Order.

9. At the direction of the Board and within ninety (90) days of the effective date of the Order, Respondent shall be enrolled in a course of personalized continuing medical education, which includes an assigned preceptor, preferably a physician board certified in the same specialty, to be approved in writing by the Director of OPMC. Respondent shall remain enrolled and shall fully participate in the program for a period of not less than three (3) months nor more than twelve (12) months.

10. Respondent shall cause the preceptor to:

a. Submit reports on a quarterly basis to OPMC certifying whether Respondent is fully participating in the personalized continuing medical education program.

b. Report immediately to the Director of OPMC if Respondent withdraws from the program and report promptly to OPMC any significant pattern of non-compliance by Respondent.

c. At the conclusion of the program, submit to the Director of OPMC a detailed assessment of the progress made by Respondent toward re-mediation of identified deficiencies.

11. During the period of the clinical competency assessment and the personalized continuing medical education program, Respondent shall be limited in his practice of medicine to (1.) practicing within the personalized continuing medical education program; (2.) performing physical examinations as part of New York disability claims; and (3.) conducting quality review of physical examinations performed as part of New York disability claims.

12. For a period of two years, to commence immediately following the completion of the approved personalized continuing medical education program, Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty (practice monitor), proposed by Respondent and subject to the written approval of the Director of OPMC.

a. Respondent shall make available to the practice monitor any and all records or access to the practice monitor any and all records or access to the practice requested by the practice monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection (no less than 15) of records maintained by Respondent, including patient records, prescribing information and office records. The frequency of practice monitoring site visits may be modified at the discretion of the practice monitor subject to the prior written approval of the Director of OPMC. The review will determine whether Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of professional medical care or refusal to cooperate with the monitor shall be reported within twenty-four (24) hours to OPMC.

b. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

c. Upon completion of the first year of monitoring, Respondent may apply to the Director of OPMC to reduce or waive the final year of monitoring. In the sole discretion of the Director of OPMC, the second year of monitoring may be waived , reduced in length, or Respondent may be required to complete the monitoring term in full.

13. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.

14. Respondent shall enroll in and complete a medical education program in the area of gastroenterology to be equivalent to at least 25 credit hours of Continuing Medical Education, over and above the recommended minimum standards set by the (specialty accrediting body). Said continuing education program shall be subject to the prior written approval of the Director of OPMC and be completed within the period of monitoring or as otherwise specified in the Order.

15. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he is subject pursuant to the Order and shall assume and bear all costs related to compliance. Upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of OPMC and/or the Board may initiate a proceeding against Respondent as may be authorized pursuant to the Law.

EXHIBIT C

TERMS OF PROSPECTIVE MONITORING

1. Commencing after the successful completion of the personalized continuing medical education program, the first 200 gastroenterology procedures Respondent performs shall be submitted to a practice monitor for approval prior to the performance of the procedure. Except in emergencies and where a patient requires a procedure within 24 hours of Respondent's initial assessment of the patient, Respondent shall not perform a gastroenterology procedure (listed below) without the prior written approval of the practice monitor, who shall certify that he/she has received and reviewed all office and hospital records pertaining to the proposed procedure and any relevant diagnostic studies and laboratory reports. Prior verbal approval will be obtained for procedures required within 24 hours of initial assessment, and the practice monitor shall subsequently review the relevant medical records in such cases and emergency cases and report to OPMC on the indications for the procedure. Approval for a procedure shall be granted upon the practice monitor's determination that appropriate medical indications exist for the proposed procedure. OPMC shall be notified immediately of any procedure in which written approval is not given. The practice monitor shall report quarterly regarding the approvals granted.

2. At least forty percent (40%) of the procedures to be monitored will be colonoscopies, colonoscopies with polypectomy or some form of those procedures. Thirty percent (30%) of the procedures to be monitored will be esophagogastroduodenoscopy (EGD) or some form of that procedure. Two percent (2%) of the procedures to be monitored will be endoscopic retrograde cholangiopancreatography or some form of that procedure.

3. The practice monitor shall be proposed by Respondent and subject to the written approval of the Director of OPMC.

4. Respondent shall be responsible for any expenses associated with monitoring, including fees, if any, to the monitoring physician.

5. Respondent shall maintain medical malpractice insurance coverage with limits no less than $ 2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.

6. After Respondent completes the first one hundred (100) procedures required by this prospective monitoring order, he may apply to the Director of OPMC to waive the remaining one hundred (100) procedures subject to this monitoring term. In the sole discretion of the Director of OPMC, the monitoring of the remaining 100 cases may be waived, reduced in number, or Respondent may be required to complete this monitoring term in full.

7. Gastroenterology procedures shall include the following:

   a. Procedures involving the Liver and Lung

   b. Pleural Biopsy (closed).

c. Small Intestinal Biopsy with Crosby Capsule and Shiner Tube.

d. Colonoscopy

e. Colonoscopy with Polypectomy or Biopsy

f. Duodenoscopy

g. Duodenoscopy with Biopsy

h. Endoscopic Retrograde Cholangiopancreatography

i. Esophagoscopy

j. Esophagoscopy with Biopsy

k. Esophageal Dilatation

l. Esophageal Tamponade with Sens taken Tube

m. Gastroscopy

n. Gastroscopy with Biopsy

o. Insertion of Esophageal Stent

p. Mediastinoscopy

q. Mediastinoscopy with Biopsy

r. Oddi Sphincterotomy

s. Percutaneous Endoscopic Gastrostomy

t. Sigmoidoscopy (Rigid or Flexible with Biopsy)

8. If Respondent receive gastroenterology privileges for procedures other than those listed, Respondent shall immediately notify OPMC who reserves the right to amend this list to include any such procedures.

9. The performance of any non-emergent gastroenterology procedure subject to these terms without prior written approval or other failure to comply with these terms will be deemed a violation of this Order.